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SEROSITIS AS THE INITIAL PRESENTATION OF SYSTEMIC LUPUS ERYTHEMATOSUS, REACTIVATED IN THE IMMEDIATE PUERPERIUM

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BACKGROUND

Systemic lupus erythematosus (SLE) is a rare, chronic, inflammatory, autoimmune, multisystemic disease of unknown etiology, with diverse clinical manifestations, and periods of exacerbations and remissions (flares). It mainly affects women in childbearing age. Serositis is frequent but a subclinical condition. In addition, it rarely progresses to cardiac tamponade or constrictive pericarditis. The treatment is individualized for each affected organ, according with its involvement.

CASE REPORT

A 23-year-old female patient developed five years ago anasarca, fatigue, intense abdominal pain and non-anginal chest pain lasting 6 months. Following a massive pericardial effusion needing a pericardiocentesis, began an investigation, presenting 1/80 reagent ANA with fine nuclear pattern, anti-Sm positive, other antibodies were negative, complement consumption and discreet photosensitivity. Putting away infectious and neoplastic causes, SLE with serous involvement was diagnosed, requiring corticosteroid pulse and cyclophosphamide therapy. After excellent clinical improvement, the follow-up ambulatory treatment was with prednisone, hydroxychloroquine and monthly pulses of cyclophosphamide. In the development, was opted to exchange the therapy for cyclosporine and low doses of corticoid, remaining the patient stable for some years. Nine months ago, when a pregnancy was discovered, the patient stopped the medications without medical guidance, but remained stable throughout her pregnancy. After the cesarean birth, the patient started with spontaneous drainage of a lot serous secretion by the operative wound, non-smell, associated with distention and abdominal pain, besides discreet dyspnea. During investigation, occurred a massive pericardial effusion and a small ascites. A new pulsoterapy was realized, but the control transthoracic echocardiography showed the maintenance of the pericardial effusion, associated to hemodynamic repercussion, being necessary a new pericardiocentesis. The patient evolved well clinically, receiving discharge from hospital with prednisolone, reintroduced hydroxychloroquine and scheduled ambulatory return. Therefore, was confirmed the reactivation of the lupus serositis due the gestational hormonal changes and the immunosuppressant drugs suspension during the gestation.

CONCLUSION

Lupus serositis is a complication found in approximately 50% of lupus patients. In this case, the patient opened the diagnosis with massive pericardial effusion requiring, in addition to immunosuppression, the pericardial window. After stabilization of the disease for some years, when got pregnant, the patient inadvertently suspended the medications, and then, in the puerperium, the disease reactivated, becoming necessary a new pericardiocentesis to relieve symptoms. This case shows us an atypical initial manifestation of SLE and how the suspension of the treatment during gestation can result in the exacerbation of the disease in the puerperium.